NHS
Eastern and Coastal Kent

Medicines Management

Benzodiazepine and Z-hypnotic (Hypnotic and Anxiolytic) Prescribing Policy

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Approving Committee/ Group	**East Kent Prescribing Group**
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VERSION CONTROL SUMMARY

Version	Date Amended	Page	Author / Amended by	Summary of Change

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Approved by: East Kent Prescribing Group
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CONTENTS

1. POLICY STATEMENT

1.1 This policy provides guidance on the prescribing of benzodiazepines and the z-hypnotics zaleplon, zolpidem and zopiclone.

2. INTRODUCTION

2.1 Illicit benzodiazepine use is common and a significant problem. There is anecdotal evidence to suggest that there is diversion of legitimate prescription supply to the black market. Benzodiazepines are not initiated in prison for offenders. This document outlines NHS Eastern and Coastal Kent cluster policy on the prescribing of benzodiazepines and the related z-hypnotics.

3. AIMS

3.1 To promote best practice regarding the use of benzodiazepines and z-hypnotics.
3.2 To promote patient safety

4. SCOPE

4.1 The policy is intended to be used in all situations where benzodiazepines and z-hypnotics are prescribed and covers all prescribers working within NHS Kent and Medway including locum and temporary staff.
4.2 Everyone involved in the use of benzodiazepines and z-hypnotics must familiarise themselves with this policy and comply with it at all times. Prescribers also have a responsibility to maintain their knowledge of the contents of this policy.

5. PURPOSE AND OUTCOME

5.1 This policy is for all clinical staff working within NHS Eastern and Coastal Kent. It aims to inform on situations where benzodiazepines and z-hypnotics may be used and sets out standards to be followed.

6. RATIFICATION AND REVIEW OF POLICY

This policy has been ratified by the East Kent Prescribing Group. The policy will be reviewed every three years and amended as necessary. The policy may be reviewed before this time if, for example, any new advice from the manufacturer or Medicines and Healthcare products Regulatory Agency (MHRA), new professional guidance and / or procedures (locally or nationally) or new legislation are introduced.

7. SUMMARY

- Benzodiazepine and z-hypnotics should be prescribed for short term use only
- There are no licensed indications for the long term prescription of benzodiazepines
- No repeat prescriptions for these drugs should be issued (only acute) unless in exceptional clinical circumstances
- Patients may become addicted to these drugs even after short-term treatment
- Existing long-term patients should be gradually withdrawn from these drugs wherever possible
- No prisoners are initiated on benzodiazepines during the course of their stay.

8. GENERAL PRESCRIBING INFORMATION

Characteristics and Costs of Selected Benzodiazepines and Z-Hypnotics

Drug	Starting Adult Dose (in elderly generally use up to half adult dose or less)	Peak onset (minutes)	Elimination half-life (usually extended in elderly) (hours)	Cost per dose (pence)
Shorter-acting benzodiazepine hypnotics				
Temazepam	10-20mg ON	30-60	5-22	10-20
Loprazolam	1mg ON	30-240	6-15	64
Lormetazepam	500mcg-1.5mg ON	30-60	10-12	1.78 5.34
Longer acting benzodiazepine hypnotics				
Nitrazepam	5-10mg ON	20-50	15-38	3-6
Z-hypnotics				
Zaleplon	10mg ON	30	2	27
Zolpidem	10mg ON	7-27	2	5
Zopiclone	7.5mg ON	15-30	5-6	5
Benzodiazepine anxiolytics (longer-acting)				
Diazepam	2mg TDS	30-60	20-100	9
Chlordiazepoxide	10mg TDS	120-240	6-30	34
Lorazepam	1-4mg daily in divided doses	60-90	10-18	16-65
Oxazepam	15-30mg 3-4 times daily	20-50	5-15	15-30

For comprehensive information on indications, contra-indications, cautions and side effects of the benzodiazepines and z-hypnotics, please refer to the latest edition of the BNF or the Summary of Product Characteristics (SPC) at http://www.medicines.org.uk.

8.1 Non-Pharmacological Interventions

8.1.1 Before treating insomnia or anxiety with benzodiazepine or z-hypnotics consider the following:

- Treat the underlying causes of insomnia e.g. depression, other psychiatric disorders, pain, pruritis, urinary frequency and dyspnoea. Sleep disturbance is very common in depressive illness and early wakening is often a useful pointer.
- Abuse of drugs and alcohol are common causes of insomnia
- Address the administration and timing of other medicines e.g. SSRIs in the morning, sedating antidepressants at night
- Consider psychological treatments including relaxation, counselling and cognitive behavioural therapy as appropriate
- Reassure the individual that 5-6 hours sleep at night is normal for older people especially if the individual “cat-naps” during the day

8.1.2 In insomnia, good sleep hygiene should be encouraged which may include the following:

- Avoid stimulants before bedtime (e.g. tea, coffee, cola, alcohol and nicotine)
- Avoid watching television, reading, eating, drinking etc in bedroom
- Increase daily exercise where possible but not before bedtime

- Get up at normal time and ensuring no lie-ins or daytime napping

8.2 British National Formulary (BNF) Advice on Indications for Benzodiazepine Use

- **Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness**
- **The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate**
- **Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress**

8.3 Prescribing Benzodiazepines

8.3.1 In the absence of intolerant adverse effects and / or contra-indicating factors (risk of abuse) the drug with the lowest purchase cost should be prescribed.

8.3.2 Benzodiazepines and z-hypnotics should usually be prescribed for short-term use only and discontinued as soon as possible. Repeat prescribing should be avoided. Tolerance can develop within 3-14 days.

8.3.2.1 Benzodiazepines should be avoided, wherever possible, in patients with a history of substance misuse except in exceptional clinical circumstances.

8.3.2.2 Transient insomnia may occur in those who normally sleep well and may be due to extraneous factors such as noise, shift work, and jet lag. If a hypnotic is indicated one that is rapidly eliminated should be chosen, and only one or two doses should be given.

8.3.2.3 Short-term insomnia is usually related to an emotional problem or serious medical illness. It may last for a few weeks and may recur; a hypnotic can be useful but should not be given for more than three weeks (preferably only one week). Intermittent use is desirable with omission of some doses. A short-acting drug is usually appropriate.

8.3.2.4 Chronic insomnia is rarely benefited by hypnotics and may sometimes be due to mild dependence caused by previous injudicious prescribing of hypnotics.

8.3.3 The quantity supplied should be limited to a maximum of 28 days' supply on any prescription. If benzodiazepines or the z-hypnotics are used for more than 4 weeks, then the reason for this must be documented in the patient's medical records.

8.3.4 If started for insomnia use short acting (e.g. temazepam) rather than long acting which give rise to residual effects on the following day and repeated dose tend to be cumulative.

8.3.5 The lowest dose that can control the symptoms should always be used.

8.3.6 Benzodiazepine and z-hypnotics should be prescribed on an intermittent "as needed" basis rather than regularly for insomnia, unless it has clearly been established and documented that hypnotics are of ongoing benefit to the patient. Consider the use of intermittent dosing (e.g. alternate nights or less). It is good practice to state the number of doses recommended during a specified period (e.g. 3 doses per week). Consecutive doses may lead to a cumulative effect.

8.3.7 Long term use is not recommended. A minority of patients with severely disabling anxiety or insomnia may benefit from longer-term treatment with a benzodiazepine. This should only be considered after careful assessment of the patient. This must be clearly documented in the patient's medical notes.

8.3.8 Where prolonged administration is unavoidable, hypnotics should be discontinued as soon as feasible and the patient warned that sleep may be disturbed for a few days before normal rhythm is re-established; broken sleep with vivid dreams may persist for several weeks.

8.4 NICE guidance on Zaleplon, Zolpidem, and Zopiclone in the short – term management of insomnia (TA77, 2004)

Zaleplon, Zolpidem, and Zopiclone are known as z-hypnotics. These are non-benzodiazepine hypnotics. They are short- to medium-acting.

8.4.1 After consideration of non-pharmacological measures, hypnotic drug therapy may be considered appropriate but should be prescribed for short periods of time only, in strict accordance with the drugs licensed indications.

8.4.2 Due to a lack of compelling evidence to distinguish between the z-hypnotics, the drug with the lowest acquisition cost (bearing in mind daily required dose and product price per dose) should be prescribed.

8.4.3 Switching between these hypnotics should only occur if the patient experiences adverse effects considered to be directly related to a specific agent. (These are the only circumstances that hypnotics with higher acquisition costs are recommended.)

8.4.4 Patients who have not responded to one hypnotic (benzodiazepines or z-hypnotics) should not be prescribed any of the others.

8.5 Benzodiazepines and z-hypnotics in Older Adults

8.5.1 All benzodiazepines and z-hypnotics should NOT be routinely prescribed in the elderly and if prescribed at all they should be used with caution as side effects are likely to be enhanced e.g. sedation, disturbance in gait, falls, daytime drowsiness, cognitive impairment, hypotension, memory impairment and reduced psychomotor performance.

8.5.2 Shorter half-life benzodiazepines are usually recommended for older adults, as they accumulate to a lesser extent in the blood and are cleared from circulation more rapidly than their longer-acting counterparts. However they may be associated with a clinically significant discontinuation syndrome and have a higher potential for abuse.

8.5.3 Anecdotal evidence suggests that diversion from legal sources to the illicit market may be an issue in the elderly patient group.

8.6 Benzodiazepines and z-hypnotics in Pregnancy

Seek specialist opinion before prescribing in pregnancy

8.6.1 Benzodiazepines and metabolites freely cross the placenta and accumulate in foetal circulation.

8.6.2 It is advisable to avoid use in the first trimester because of risks of teratogenicity (association with incidence of cleft palate).

8.6.3 High doses or prolonged use by the mother in the third trimester may precipitate foetal benzodiazepine syndrome including floppy infant syndrome, impaired temperature regulation and withdrawal symptoms in the newborn.

8.6.4 The z-hypnotics should not be prescribed during pregnancy.

8.7 Benzodiazepines and z-hypnotics in Lactation

Seek specialist opinion before prescribing to a breastfeeding mother

8.7.1 Benzodiazepines are excreted in breast milk in levels sufficient to produce effects in the newborn, including sedation, lethargy, and poor temperature regulation.

8.7.2 Metabolism in infants is slower especially during the first 6 weeks and benzodiazepines can accumulate in the infant.

8.7.3 Z-hypnotics are not recommended by manufacturers in lactation. They are excreted in breast milk.

9. PRESCRIBING IN DEPENDENCE AND WITHDRAWAL

9.1 Introduction

9.1.1 The *short term* prescribing of benzodiazepines as an aid to assisting withdrawal may have some benefit in supporting users to control their intake of benzodiazepines and stabilise their lives. It may also help to reduce contact with illicit drug markets.

9.1.2 The benefit of *long term* prescribing of benzodiazepines is less certain with increasing evidence that long term prescribing of more than 30mg diazepam daily may be harmful. A prolonged prescription for benzodiazepines to a person with an illicit benzodiazepines habit rarely results in abstinence and more often ends in long term prescribing or continued illicit use. It is therefore of doubtful therapeutic value. Benzodiazepine use has been cited as a significant factor in combination with methadone and buprenorphine and / or alcohol in drug related deaths.

9.1.3 No benzodiazepines are initiated in prison but if a patient is admitted already on benzodiazepines the prison will reduce the dose to aid withdrawal. It is therefore possible that a small number of patients may leave prison still on a withdrawal dose. There does, however, seem to be a trend in former prisoners seeking benzodiazepines after release.

9.1.4 Withdrawal from long term benzodiazepine use should be gradual because abrupt withdrawal may cause withdrawal symptoms including rebound insomnia, anxiety, depression, perceptual disturbances, delusions and hallucinations, toxic psychosis, depersonalisation, decreased memory and concentration, nightmares, convulsions, a condition resembling delirium tremens, tremor, loss of appetite, weight loss, GI disturbances, perspiration, tinnitus, parasthesia, visual disturbances, stiffness, weakness and 'flu-like symptoms. Some symptoms may be similar to the original complaint and encourage further prescribing. The benzodiazepine withdrawal syndrome is a recognised condition which occurs in at least a third of long-term users on dosage reduction. Withdrawal symptoms may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but can occur within a day in the case of a short-acting one. In the majority of patients, withdrawal symptoms last no longer than a few weeks, although a minority experience disabling symptoms, which can persist for months or years.

9.2 Assessment

9.2.1 "Binge" use of benzodiazepines is common and a benzodiazepine prescription a desirable commodity amongst this patient group but not clinically appropriate as use is acute and not chronic.

9.2.2 It is therefore essential that a detailed assessment of usage is carried out and dependency is confirmed before a prescription is issued. Assessment must include:

- Amount used and times of usage (to identify "binge" use)
- Duration and frequency of consecutive use
- Reason for taking the benzodiazepine e.g. anxiety, insomnia, to help "come down" from stimulants in order to address the underlying problem
- The presence or absence of withdrawal symptoms to evaluate whether withdrawal syndrome is actually present.
- Alcohol use (so this problem may be addressed)
- Illicit drug use (so this problem may be addressed)

9.3 Management of withdrawal

9.3.1 Non-prescribed interventions to reduce the benzodiazepine use should be explored and a benzodiazepine prescription should only be considered when other options have failed or been excluded.

9.3.2 There is no "gold standard" treatment for benzodiazepine dependency and withdrawal.

9.3.3 Benzodiazepines should not be prescribed routinely in the treatment of illicit benzodiazepine dependence.

9.3.4 Benzodiazepines are not licensed for the management of benzodiazepine dependence; they are licensed only for short-term use for the management of insomnia and anxiety.

9.3.5 Benzodiazepine prescriptions for dependency should be on a reducing schedule rather than a maintenance schedule; with clear goals and milestones; regular review and methods to prevent diversion.
9.3.6 All benzodiazepines should be converted to an equivalent daily dose of diazepam[(1)] which has a long half-life and therefore provokes less severe withdrawal symptoms.

[(1)] Approximate equivalent doses, diazepam 5 mg
≡chlordiazepoxide 15 mg
≡loprazolam 0.5–1 mg
≡lorazepam 0.5–1 mg
≡lormetazepam 0.5–1 mg
≡nitrazepam 5 mg
≡oxazepam 15 mg
≡temazepam 10 mg

9.3.6.1 Diazepam is licensed for short-term use in anxiety or insomnia (two to four weeks only) and as an adjunct in acute alcohol withdrawal.
9.3.6.2 It is used in benzodiazepine withdrawal and dependency but these are both outside licensed indication
9.3.6.3 Doses should not exceed 30mg diazepam daily unless initiated by a specialist in the field of substance misuse.
9.3.6.4 Caution is advised with the co-prescribing of benzodiazepines with opioids especially where alcohol misuse is also an issue.
9.3.6.5 Liver disease may necessitate a reduction in dose or a transfer to a benzodiazepine that is not metabolised by the liver e.g. oxazepam. Decision to treat should be made in conjunction with a specialist in the field of substance misuse and a hepatology specialist.
9.3.7 Following conversion to an equivalent diazepam dose, the prescriber should aim for the lowest dose that will prevent withdrawal symptoms to a maximum of 30mg daily of diazepam.
9.3.7.1 If a dose of greater than 30mg daily is deemed necessary then this should be discussed with a specialist before initiating the prescription.
9.3.7.1.1 If claimed usage is high (in excess of 60mg daily) then the starting dose should be substantially less than the claimed use.
9.3.7.1.2 There is consensus that there are no indications for prescribing higher than 60mg daily.
9.3.7.1.3 Research has indicated that in high dose usage, much lower doses than those consumed are adequate to prevent the onset of withdrawal symptoms.
9.3.7.1.4 If it is confirmed that the patient is on large doses, in-patient stabilisation or detoxification may be required.
9.3.7.2 The BNF suggests taking the full dose of diazepam at night
9.3.8 Where the patient is also on a methadone or buprenorphine maintenance prescription, this should be held on the current dose whilst the diazepam is reduced.
9.3.9 All patients in receipt of a benzodiazepine prescription should be reviewed frequently and regularly.
9.3.10 Reduction regimes should be the goal of care.
9.3.10.1 The rate of reduction is often determined by the individuals' capacity to tolerate withdrawal symptoms.
9.3.10.2 A benzodiazepine can be withdrawn in steps of about one-eighth (range one tenth to one quarter) of daily dose every fortnight.
9.3.10.3 The BNF suggests the following withdrawal protocol for patients who have difficulty:

- Reduce diazepam dose every 2–3 weeks; if withdrawal symptoms occur, maintain this dose until symptoms improve
- Reduce dose further, if necessary in smaller steps; it is better to reduce too slowly rather than too quickly. Steps may be adjusted according to initial dose and duration

of treatment and can range from diazepam 500micrograms (one-quarter of a 2mg tablet) to 2.5mg
- Stop completely; period needed for withdrawal can vary from about 4 weeks to a year or more

9.3.10.4 Counselling may help; beta-blockers should **only** be tried if other measures fail; antidepressants should be used **only** where depression or panic disorder co-exist or emerge; **avoid** antipsychotics (which may aggravate withdrawal symptoms).
9.3.10.5 Continuing support is required for patients including psychological therapies, self help groups and family support.

10. ADVERSE DRUG REACTONS, MONITORING AND REPORTING

10.1 Benzodiazepine and z-hypnotic adverse events are well known and include hangover effects, daytime drowsiness, confusion, amnesia and psychomotor effects, ataxia and increased risk of falls. (A large observational study found an increased incidence of hip fracture associated with benzodiazepine use, after adjusting for confounders (e.g. age, gender, nursing home occupancy).
10.2 These adverse effects are more common and more pronounced in the elderly.
10.3 Benzodiazepine and z-hypnotics are also known to increase the risk of road traffic accidents. (In a large observational study of Norwegian drivers aged 18 to 69 years, people prescribed zopiclone or zolpidem in the previous seven days had double the risk of road traffic accidents, compared with people not prescribed hypnotics.)
10.4 Adverse effects do not appear to differ significantly frequency between benzodiazepines and z-hypnotics.
10.5 Any medicine may produce unwanted or unexpected adverse reactions. Detection and recording of these is of great importance for patient safety.
10.6 All healthcare professionals with responsibility for the prescribing, monitoring and dispensing of medicines must be aware of the adverse drug reactions of benzodiazepines and z-hypnotics.
10.7 Practitioners should monitor the patient and record suspected adverse effects of medicines in the medical notes.
10.8 Service users should be prompted to report or discuss any adverse effects they believe they may be experiencing as a result of their medication.
10.9 Service users must always be provided with written information on the possible side effects of the medication they are taking.
10.10 Newly licensed medicines are monitored intensively by the Medicines and Healthcare Products Regulatory Agency (MHRA) and are identified by a black triangle symbol in the British National Formulary (BNF).
10.11 Where an adverse reaction to a medicine is considered to be serious OR involves a “black triangle” (▼) medicine, it must be reported to the MHRA. Reporting can be carried out on-line using the website www.yellowcard.gov.uk. Alternatively adverse drug reactions may be reported via post pre-paid yellow cards are available at the back of the BNF.

11. CONSENT

11.1 Benzodiazepines and the z-hypnotics should only be prescribed after informed consent has been obtained.
11.2 If the individual is not of sufficient age or understanding, a person with parental / carer responsibility will normally be required to give consent.

12. PATIENT INFORMATION

12.1 Prior to initiation of therapy, clinicians must discuss the risks and benefits of benzodiazepines and z-hypnotics.
12.2 The discussion should include the following:
- The reasons / indication for the use benzodiazepines / z-hypnotics
- The risks and potential benefits of treatment including

- The effects to expect and common adverse effects and interactions
- The risk of dependence with prolonged use
- How medication will be withdrawn or adjusted as appropriate

12.3 At the point of dispensing, written information must be provided for the patient and / or carer in a format that takes account of the patient's educational and communication needs. The minimum information provided should be the patient information leaflet. The manufacturer's patient information leaflet may be downloaded from http://www.medicines.org.uk.

12.4 Supporting documents are included in section 17 of this document.

13. RESPONSIBILITIES

13.1 Prescriber and Practice responsibilities

13.1.1 Ensure that all benzodiazepines and z-hypnotics are prescribed appropriately and reviewed in line with this policy.

13.1.2 All benzodiazepines and z-hypnotics should be reviewed on a regular basis with clear documentation in the patient's medical notes.

13.1.3 If benzodiazepines or z-hypnotics are used for more than 4 weeks, then the reason for this must be documented in the patient's medical notes.

13.1.4 Ensure that appropriate monitoring is in place when patients are prescribed benzodiazepines and when such patients have a respiratory illness (e.g. asthma), liver impairment, alcohol or illicit drug dependence.

13.1.5 Provide patients with information and advice leaflets on the prescribed treatment. The information about treatment should be in accessible formats that takes into account, for, example, their education and communication needs.

13.1.6 Ensure **no** new prescriptions for benzodiazepines and z-hypnotics are entered onto repeat prescribing systems.

13.2 Pharmacist and Pharmacy responsibilities

13.2.1 Ensure prescribing of benzodiazepines and z-hypnotics are in accordance with this policy and national guidelines.

13.2.2 Monitor prescriptions for patient appropriateness including indication, dose, efficacy and side effects.

13.2.3 Dispense appropriately labelled supply of benzodiazepines / z-hypnotics medication in accordance with a legal / valid prescription.

13.2.4 Ensure that duration of benzodiazepines and z-hypnotics are monitored, queried and if appropriate discontinued.

13.2.5 Provide the patient with information and advice leaflets on their medication.

14. TRAINING

14.1 Each profession's Code of Practice will indicate what is expected from practitioners to satisfy its continuous professional development requirements with regards to medicines management.

14.2 Professionals involved with the medicines management systems are responsible for ensuring that their knowledge is up to date and they are aware of clinical policies related to their work. Professionals should reinforce and update knowledge and skills in the area of medicines management.

15. INCIDENT REPORTING

15.1 All incidents must be reported in accordance with the relevant incident reporting policies:

15.2 Incidents involving Controlled Drug CD.kent@nhs.net.

15.3 Medicines incidents (not involving Controlled Drugs) either

- Complete a reporting form and email to medicines.kent@nhs.net (this is the new email address for reporting incidents involving non CD medications.)

- Use the online reporting facility on the National Reporting and Learning Service http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/. (Please remember to tick the "Share with Trust" option when completing the form.)

16. REFERENCES

1. British National Formulary No 63 (March 2012) www.bnf.org
2. Summary of Product Characteristics http://www.medicines.org.uk
3. NICE Technology Appraisal 77 Guidance on the use of Zaleplon, Zolpidem, Zopiclone for the short-term management of insomnia. http://www.nice.org.uk
4. Prodigy http://prodigy.clarity.co.uk/insomnia
5. Benzo.org.uk http://www.benzo.org.uk/
6. Vancouver Coastal Health http://www.vhpharmsci.com/vhformulary/tools/benzodiazepines-comparison.htm
7. The Maudsley 2005-2006 Prescribing Guidelines. 8th Edition. Taylor and Francis
8. Psychotropic Drug Directory 2001-2002. Stephen Bazire
9. NPC MeReC Bulletin Vol.22 No.04. February 2012

17. SUPPORTING DOCUMENTS

17.1 Sleep Diary
17.2 Anxiety Diary
17.3 Suggested patient letter to accompany benzodiazepine or z hypnotic prescription
17.4 Suggested patient letter regarding ongoing treatment and invitation to reduce treatment
17.5 Advice for patients on reducing benzodiazepines
17.6 Suggested doctor patient agreement for reducing benzodiazepines
17.7 Good Relaxation Guide for Patients
17.8 Good Sleep Guide for Patients
17.9 Help with Sleep - Information for Carers looking after Older People

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

SLEEP DIARY

It will help us to find the best way to deal with the problem you are having with sleep at the moment if you can keep a sleep diary for a short time. All you have to do is to use the chart below to note down the pattern of your sleep (how much you sleep and when) and the quality of your sleep. It is best to try to fill in the diary as soon as possible after getting up; it only takes a few minutes. If this is not possible, make sure you fill it in before the end of the day – it is very difficult to remember details of sleep after more than one night.

When you come back to see me, we can discuss what you have written in your sleep diary. This should help us to decide together the best way to deal with the problem.

Name .....

Measuring the Pattern of Your Sleep

		Day 1	2	3	4	5	6	7
1.	At what time did you get up this morning?							
2.	At what time did you go to bed last night?							
3.	How long did it take you to fall asleep (mins)?							
4.	How many times did you wake up during the night?							
5.	How long were you awake during the night (in total)?							
6.	About how long did you sleep altogether (hours/ minutes)?							
7.	How much alcohol did you take last night?							
8.	How many sleeping pills did you take to help you to sleep?							

Measuring the Quality of Your Sleep

Please answer these questions about the quality of your sleep using the following scale:

0 Not at all 1 2 Moderately 3 4 Very

		Day 1	2	3	4	5	6	7
1.	Do you feel well this morning?							
2.	How enjoyable was your sleep last night?							
3.	How mentally alert were you in bed last night?							
4.	How physically tense were you in bed last night?							

ANXIETY DIARY

It will help us to find the best way to deal with the anxiety you are feeling at the moment, if you can keep an anxiety diary for a short time. Use it to keep a note of when and where you feel anxious, and how anxious you feel. The chart below is designed to make this as easy as possible. The best way to record how anxious you feel is by using an anxiety scale. On this chart the scale is 0-10, where 0 = not anxious at all, 5 = moderately anxious and 10 = extremely anxious.

By filling in the chart it will be easier to identify the times and situations where you feel most anxious. When you come back to see me, we can discuss what you have recorded in your anxiety diary. This should help us to decide together the best way to deal with the problem.

Name: ……………………………………………………………………………………………………

Day, date & time	Where are you?	What are you doing?	Anxiety scale 0 – 10
Example **Tuesday 31 Jan 22.10**	*Watching news on the TV*	*News of a disaster*	0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely
			0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely

Adapted from original material in the report of the Scottish National Medical Advisory Committee on the management of anxiety and insomnia

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

Suggested patient letter to accompany benzodiazepine or z hypnotic prescription

Dear ……,

You have been prescribed ……, one of a group of medicines known as hypnotics and anxiolytics. This medicine can help you cope with a short period of severe stress or anxiety and help sleep problems; it is not intended for long-term treatment and can be habit forming.

If you are being treated for sleeplessness you will be given tablets for a few nights only. Treatment for longer often makes sleep difficulties worse and may even make it difficult to stop the drug, so please do not ask for further supplies when these run out.

Try to do without a sleeping tablet 1, 2 or 3 nights a week.

Avoid drinks such as coffee, tea and cola after 3.00 pm; these contain caffeine, which can keep you awake. Avoid late-night exercise and mental stimulation.

If you are being treated for anxiety you will be given a supply of medicine for a short period of time.

Avoid alcoholic drinks when you are taking a benzodiazepine, particularly when first starting treatment.

Do not drive or operate machinery while you are under the effects of these drugs.

Yours sincerely.

Dr …….

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

Suggested patient letter regarding ongoing treatment and invitation to reduce treatment

Dear ……,

I am writing to you because I note from our records that you have been taking …….. for some time now.

There is concern about this kind of medication when it is taken over long periods of time. The concern is that the body can get used to these tablets so that they no longer work properly. If you stop taking the tablets suddenly, you may experience unpleasant withdrawal effects. For these reasons, repeated use of the tablets over a long time is not recommended. More importantly, these tablets may actually cause anxiety and sleeplessness and they can be addictive.

I am writing to ask you to consider cutting down on your dose of these tablets and perhaps stopping them at some time in the future. The best way to do this is to take the tablets only when you feel they are absolutely necessary. In this way you might be able to make a prescription last longer.

Once you have begun to cut down, you might be able to think about stopping them altogether. It would be best to cut down very gradually and then you will be less likely to have withdrawal symptoms.

If you would like to talk to me personally about this, I would be delighted to see you in the surgery whenever it is convenient for you to attend.

Yours sincerely,

Dr …….

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

Reducing your Benzodiazepines

ADVICE FOR PATIENTS

What are benzodiazepines?
Benzodiazepines are drugs that can reduce anxiety and help sleep problems. They should only be used for very short periods in patients with severe symptoms.

What are the effects?

Short term:
- Reduced alertness.
- Drowsiness. This may affect your ability to drive or operate machinery.
- Reduced tension and anxiety.

Long term:
- Dependence on the drug.
- Reduced alertness may lead to accidents or falls.
- Poorer memory.
- Lack of emotion.
- Tasks take longer to complete.
- The short-term effects continue.

What may happen when the drug is withdrawn?
- Your muscles may ache and strange sensations may be felt on the skin.
- You may feel restless and anxious.
- You may feel sick and weight loss may occur.
- You may sweat more than normal.
- You may have difficulty sleeping.
- You may feel more frightened or panicky. At first you can have a reduced ability to cope with stress.
- Eventually your anxiety will disappear and you will become more assertive.

Why does this happen?
- Benzodiazepines in the brain block your emotional responses.
- When you reduce the drug, your brain becomes over-stimulated again. This can magnify your feelings and senses.

This is why your doctor will very slowly reduce your medication to ease the withdrawal process. Hopefully these side effects will be kept to a minimum.

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

Suggested doctor patient agreement for reducing benzodiazepines

Benzodiazepine Withdrawal Agreement

I …….. understand and agree to the following in relation to my participation in a benzodiazepine withdrawal programme.

1. The purpose of the plan is to help me stop using benzodiazepines, it comprises prescribed benzodiazepine tablets and counselling.
2. I have been advised that counselling is an important part of helping me to stop taking benzodiazepines.
3. I agree to keep and be on time for all my scheduled appointments. I agree that my medication / prescription can only be given to me at my regular appointments. A missed visit may result in my not being able to get my medication / prescription until the next scheduled visit.
4. I agree to conduct myself in a courteous manner in the practice and the pharmacy.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the practice or pharmacy.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by the practice or the pharmacy where my prescription is filled, that the behaviour will be reported to my doctor and could result in my treatment being terminated without any recourse for appeal.
7. I agree that any benzodiazepine tablets in my possession are my responsibility and I agree to keep it in a safe, secure place and I agree that if I lose or misplace them, they will not be replaced, regardless of why it was lost.
8. I will abide by any rules and responsibilities of the clinic / surgery and pharmacy.
9. I will not get benzodiazepines from any other source (e.g. other doctors, buying them from people) nor will I exchange them for other drugs.
10. I will not take non-prescribed drugs while on the benzodiazepine reduction regime as this can be dangerous (especially other sedative drugs including alcohol and opiates e.g. heroin, morphine, methadone, buprenorphine). I understand that mixing benzodiazepines with other medications, can be dangerous. I also recognise that several deaths have occurred among persons mixing benzodiazepines and other drugs (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counselling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and could result in my treatment being terminated without any recourse for appeal.

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15. I understand that violations of the above may be grounds for termination of treatment.
16. I have been advised that driving a vehicle or operating machinery is not safe while taking benzodiazepines such as diazepam.

Personalised dose reduction plan for ……

Week(s)	Dose

Patient signature …….. Date ……

Doctor / witness signature …… Date ……

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

The Good Relaxation Guide

DEALING WITH PHYSICAL TENSION

The following tips should help towards better relaxation

1. Value times of relaxation. Think of them as essentials not extras. Give relaxation some of your best time not just what's left over.
2. Build relaxing things into your routine every day and take your time. Don't rush. Don't try too hard.
3. Learn a relaxation routine, but don't expect to learn without practice.
4. There are many relaxation routines available. These can help you to reduce tension and to learn how to use your breathing to help you relax.
5. Tension can show in many ways – aches, stiffness, heart racing, perspiration, stomach churning etc. Don't be worried about this.
6. Keep fit. Physical exercise, such as a regular brisk walk or a swim, can help to relieve tension.

DEALING WITH WORRY

1. Accept that worry can be normal and that it can be useful. Some people worry more than others but everyone worries sometimes.
2. Write down your concerns. Decide which ones are more important by rating each of them out of ten.
3. Work out a plan of action for each problem.
4. Share your worries. Your friends or your doctor can give you helpful advice.
5. Doing crosswords or sudoku, reading, taking up a hobby or an interest can all keep your mind active and positive. You can block out worrying thoughts by mentally repeating a comforting phrase.
6. Practice enjoying quiet moments, e.g. sitting, listening to relaxing music. Allow your mind to wander and try to picture yourself in pleasant, enjoyable situations.

DEALING WITH DIFFICULT SITUATIONS

1. Try to build up your confidence. Try not to avoid circumstances where you feel more anxious. A step by step approach is best to help you face things and places which make you feel tense. Regular practice will help you overcome your anxiety.
2. Make a written plan and decide how you are going to deal with difficult situations.
3. Reward yourself for your successes. Tell others. We all need encouragement.
4. Your symptoms may return as you face up to difficult situations. Keep trying and they should become less troublesome as your confidence grows.
5. Everyone has good days and bad days. Expect to have more good days as time goes on.
6. Try to put together a programme based on all elements in 'The Good Relaxation Guide' that will meet the needs of your particular situation.

Remember that expert guidance and advice is available if you need further help.

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

The Good Sleep Guide

The following tips should help you get into a good sleep pattern:

DURING THE EVENING

1. Put the day to rest. Think it through. Tie up loose ends in your mind and plan ahead. A notebook may help.
2. Take some light exercise in the early evening.
3. Wind down in the course of the evening. Try and avoid anything mentally demanding within 90 minutes of bedtime.
4. Don't sleep or doze on the sofa or armchair. Try to keep your sleep for bedtime.
5. Avoid drinks such as coffee/tea/cola after 6pm. These contain caffeine and can keep you awake. Do not eat a heavy meal before bedtime.
6. Make your bed and bedroom comfortable. Not too cold or hot.

AT BEDTIME

1. Go to bed when you are "sleepy tired" and not before.
2. Do not read or watch TV in bed. Try to keep these activities for another room.
3. Set the alarm for the same time every morning until your sleep pattern settles down.
4. Put the lights out when you get into bed.
5. Consider trying a relaxing drink such as camomile tea, Horlicks or Ovaltine.
6. Let yourself relax and tell yourself that sleep will come when it's ready.
7. Enjoy relaxing even if at first you don't fall asleep.

IF YOU HAVE PROBLEMS

1. Sleep problems are common and not as damaging as you might think. Try not to get upset or frustrated.
2. If you are awake in bed for more than 20 minutes then get up and go into another room.
3. Do something relaxing for a while and don't worry about tomorrow. People usually cope quite well after a restless night. Try reading something light or listen to relaxing music.
4. Go back to bed when you are "sleepy tired".
5. Remember the tips from the section above and use them again.
6. A good sleep pattern may take a number of weeks to establish. If you have had sleep problems for years then it can take longer. Be confident that you will get there in the end!

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

Help with Sleep -
Information for Carers Looking After Older People

- Older people need less sleep at night, particularly if they doze during the day.
- It is important to have a set time for getting up. The time for going to bed can be more flexible.
- It is normal for older people to awaken several times during the night. This isn't harmful. Being awake does not necessarily mean that the individual is distressed. Resting in bed can be almost as good as sleeping.
- A good night's sleep may follow a sleepless night, without the need to resort to a sleeping pill.
- Physical symptoms, especially pain, which disturb sleep should be treated in their own right.
- The doctor should be alerted to symptoms of depression or anxiety.
- A range of activities should be encouraged in order to have an interest and alertness in life.
- Sleeping pills are addictive. They should only be used for days when they are really needed.
- Sleeping pills can have 'hangover' effects the next day causing difficulty with concentration, dizziness, drowsiness and falls.
- As a carer, you should feel able to discuss your own feelings with the doctor. You are entitled to periods of respite care to enable you to have a much needed break!

Prepared By: Brigid Baxter
Approved by: East Kent Prescribing Group
Date approved: June 2012

18. Equality Impact Assessment

Revised: July 2011 (post-Clustering)

An Equality Impact Assessment must be completed when developing a new function, policy or practice, or when revising an existing one.
In this context a function is any activity of NHS Kent and Medway, a policy is any prescription about how such a function or service is carried out, for instance a strategy, guidelines or manual, and a practice is the way in which something is done, including key decisions and common practice in areas not covered by formal policy.
For the purpose of brevity "function, policy and practice" will be collectively refered to as "policy" throughout this template.

Name of policy

Benzodiadepine and Z-hypnotic Prescribing Policy

Owner of policy

Medicines Management Team

Author of EIA

Brigid Baxter

Date EIA was completed

22 June 2010

Directorate

Medicines Management

Please see explanatory notes for further information

Aims

What are the aims of the policy?

To promote best practice regarding the use of benzodiazepines and z-hypnotics.
To promote patient safety

Effects

What effects will the policy have on staff, patients, and other stakeholders?
Are there any barriers (communication, physical access, location, sensitivity etc.) which could inhibit access to / the benefits of the policy?

Safer prescribing of benzodiazepines and z-hypnotics.

Evidence

Is there any existing evidence of this policy being relevant to any equality issues?

Identify existing sources of information about the operation and outcomes, such as operational feedback (including monitoring and impact assessments) inspectorate and other relevant reports/complaints and litigation/relevant research publications etc. Does any of this evidence point towards relevance to any of the equalities issues?

No.

Stakeholders and feedback

Describe the target group for the policy and list any other parties which will be affected by it.

Prescribers of benzodiazepines and z-hypnotics.

What contact have you had with these groups (in relation to this policy)? Please also record your feedback here.

East Kent Prescribing Group approved the policy.
Patient Reference Group support implementation of the policy.

Assessment of relevance to/impact on equality issues

Equality Strand	Negative Impact High/ Medium/Low	Positive Impact High/ Medium/Low	Rationale
Race and Ethnicity			N/A
Gender			N/A
Pregnancy and Maternity			N/A
Sexual Orientation			N/A
Gender Reassignment			N/A
Disability			N/A
Religion or Belief			N/A
Age			N/A
Marriage and Civil Partnership			N/A

If you have answered high or medium to negative impact for any of the equality strands a comprehansive impact assessment must be completed, unless it can be justified that to do an extensive EIA is not a proportionate response. The justification for not completing a comprehensive EIA must be provided to the EDHR team or the Diversity Champions Network.

Outcomes of equality impact assessment

What are the key areas of positive or negative impact and the implications of these?

If a comprehensive EIA is not necessary, what is your justification for this?

Any mitigation actions that have been taken:

Issue to be addressed	Action to be taken	Director responsible	Target date

Monitoring and review arrangements

Describe the systems that you are putting in place to manage the policy and to monitor its operation and outcomes in terms of the various equalities issues.

State when a review will take place and how it will be conducted

June 2014 or sooner if required. Ensure policy is in line with current evidence.

	Name (in CAPS) and signature	Date
Policy Lead	Brigid Baxter	22 June 2012
Director		